structures has obvious clinical significance in a situation like placenta previa or before amniocentesis. At the same time, structures, margins and surfaces can be evaluated with the gray scale technique for other types of placental pathology such as abruptio. Molar pregnancy can be diagnosed quite early since it produces a typical echo pattern.

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Ambulatory Surgical Gynecology

GYNECOLOGICAL SURGICAL PROCEDURES that are brief and low risk and for which postoperative care is simple (such as dilatation and curettage) may often be best done on a come-and-go basis in a surgical facility which has been especially designed for ambulatory patients. Such a facility may be developed in a physician's office, a clinic, a separate facility ("surgicenter") or a general hospital. It must be equipped to provide all the safeguards that are standard in a general hospital. The entire facility, its maintenance and its records, must be accessible for peer evaluation and review.

Whether general anesthesia or local anesthesia is used, the ambulatory surgical facility should provide adequately maintained monitoring and resuscitation equipment. Local infiltration or paracervical block anesthesia, possibly supplemented by intravenously administered diazepam (Valium®), is often satisfactory to both patient and physician. If general anesthesia is used, it should be professionally administered. Careful preoperative evaluation to insure low risk status and competent immediate recovery care must be provided. However, after the patient has recovered from general ansthesia, further postoperative care by loved ones in the familiar surroundings of home may be as safe and far more agreeable than the regimented professional routines normally provided by hospitals to inpatients.

Lesions of the vulvae, such as Bartholin cysts needing marsupialization, sebaceous cysts needing excision, suspicious skin or mucosal lesions needing biopsy, perineal stenoses needing reverse perineorrhaphy and even breast biopsies, may usually be managed satisfactorily under local anesthesia. Dilatation of the cervix, uterine curettage, difficult intrauterine device insertion or removal, cervical cauterization, superficial conization and menstrual extractions, may all be performed under paracervical block anesthesia using mepibacaine hydrocloride (Carbocaine®) and lidocaine. Laparoscopy and extensive cervical cold conizations on come-and-go patients are more commonly done under general (thiopental [Pentothal®]) anesthesia. Preoperative risk evaluation must always be done. Patients who are high in surgical risk due to advanced age, severe anemia or vascular diseases, should, of course, be admitted to a hospital for treatment.

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Lymphangiography and Cervical Cancer

THE IDEAL METHOD for the detection of lymph node metastases in patients with cervical cancer would be accurate, easy to carry out and easy to interpret, and would not require exploratory operation. Though lymphangiography does not meet all these requirements, it is better than any other available method. Negative lymphangiographic results are not of much value because (1) not all nodes in the pelvic and aortic areas are normally visualized and (2) metastases less than 3 mm in size are not seen as defects in the node. Nevertheless, when lymphangiograms give positive results (and are done by experts and evaluated using strict criteria), they are reliable. The finding of a lymph node filling defect not transversed by lymphatics is the most reliable criterion for identifying metastasis. Other findings such as lymphatic obstruction, collateral circulation or stasis may result from other causes and are not sufficiently reliable to be useful clinically.

Many centers employ lymphangiography as an orientation technique to be used for patients in whom routine surgical exploration with lymph node biopsy of lymphangiographic suspicious areas is to be done. Should biopsy specimens show the presence of metastatic carcinoma in aortic lymph nodes, treatment portals are enlarged to include

the para aortic nodal areas to the level of the 12th thoracic vertebra. Some patients in whom positive aortic nodes have been so treated are apparently living free of tumor, but further studies of larger numbers are necessary to determine how many patients will benefit from these additional measures. At present, lymphangiography in cervical cancer is most useful when other diagnostic and therapeutic steps, such as surgical staging and expanded aortic treatment fields, are available. Because of the urgent need for accurate information about lymph node metastases, efforts to improve the usefulness of lymphangiography should continue.

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The Oxytocin Challenge Test

THE OXYTOCIN CHALLENGE TEST (OCT) is a method currently being used to evaluate uteroplacental respiratory function before labor. The test is done by recording fetal heart rate (FHR) and uterine contractions (UC) on a strip chart by means of a suitable external fetal monitor. The FHR response of late deceleration suggests uteroplacental respiratory insufficiency as shown by Hon and others during intrapartum fetal studies. Uterine contractions are known to interfere with uterine blood flow and are used in this test to provide an intermittant hypoxic stress to the fetus. If the FHR response to spontaneous or oxytocin-induced uterine contractions that are occurring at a frequency of three per 10 minutes shows no late decleration (negative OCT), the fetus is believed to be in little or no danger of intrauterine demise for one week following the OCT. When persistent late deceleration of the FHR is present the patient is said to have a positive OCT and one can no longer be assured that the fetus will survive continued intrauterine existence. If fetal maturity is likely (lecithin-sphingomyelin ratio, $L/S>2.0$) delivery would seem advisable. However, it should be emphasized that the positive OCT does not always signify imminent fetal danger and one should use other methods to assess fetal well-being (for example, a 24-hour urinary estriol test) when the OCT is positive and fetal maturity is unlikely ($L/S<2.0$).

The OCT gives rapid information about fetal well-being and has not been associated with an increased incidence of premature labor. It appears that the clinical value of the OCT is to allow one to avoid unnecessary premature delivery in patients at high risk for antepartum uteroplacental insufficiency.

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Cryosurgery

THE MANAGEMENT of benign diseases of the visible portion of the female genital tract has been significantly simplified following the introduction of cryosurgical therapy to the physician's armamentarium. Chronic cervicitis, that is, columnar tissue on the ectocervix, has been shown to respond favorably to outpatient cryotherapy with minimal complications. The success rate approaches 90 percent, and the technique is superior to hot cautery and avoids the hazards as well as expense of conization of the cervix. In fact, with the advent of cryosurgery, cervical conization is no longer warranted as treatment for "cervicitis."

When a physician desires to treat a patient with freezing for benign cervical disease, a Papanicolaou test must first be given and normal results obtained. Freezing is best done right after a menstrual period. During the treatment session, which is done without anesthesia or analgesia, it is most important that the iceball extend at least three to four millimeters onto healthy appearing tissue.

Cryosurgical therapy is also of benefit in the management of patients with resistant condyloma acuminata of the vulva, that is, non- or partially-responsive to podophyllin. When using the technique in a patient with vulvar condyloma acuminata, it is important to thoroughly freeze the base of the vulva but not an area greater than 2 or 3 cm in diameter in order to avoid excessive post-treatment complications.

The only significant sequela following cryosurgery has been a profuse watery discharge. Cervical stenosis and postoperative hemorrhage have not